Northeast Youth & Family Services
Transforming Lives

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I, _____ (patient name), hereby consent to engage in telehealth with Northeast Youth & Family Services (NYFS) as part of my psychotherapy. I understand that telehealth includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to healthcare practitioners located within Minnesota, and outside of Minnesota.

Telehealth is a means of using electronics to receive therapy. Teletherapy may or may not be as effective as in-person therapy, and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

All telehealth services must be received within the state of Minnesota and clients must reside within the state of Minnesota in order to comply with the laws related to confidentiality. The therapist is required to provide services to you from a private, confidential setting. You, as the client, are also required to receive teletherapy in a private, confidential setting.

I understand that I have the following rights with respect to telehealth:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss of withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. There are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

  In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services), I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improved and in some cases may even get worse.

- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured
- I understand that if I am in need of emergency mental health services, I may contact my local emergency room.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Minnesota law.

I have read and understand the information provided above. I have discussed it with my therapist and all of my questions have been answered to my satisfaction.

Signature of patient/parent/guardian/conservator. If signed by other than patient, indicate relationship.

_____
Print Name

_____ _____
Patient's Signature or Personal Representative's Signature Date

_____
If Personal Representative, describe relationship